Dermatopathology Approved Protocol Selections

Practice Name _____ **Account Number** _____

At my request, I hereby authorize Inform Diagnostics to perform the Approved Protocols, as provided, that I believe to be medically necessary and appropriate* for the diagnosis and/or treatment of my patients, on specimens that I forward to Inform Diagnostics for diagnostic workup.

It is Inform Diagnostics' responsibility to emphasize clinician choice, proper disclosure, client/clinician education, and to facilitate the ability of a client/clinician to order any testing that he/she believes to be medically necessary and appropriate** for the diagnosis and/or treatment of his/her patients.

Please provide your approved protocols

Your protocol selections will be implemented within 24–48 hours from receipt at Inform Diagnostics.

Please note that this Approved Protocol Form supersedes and replaces any existing Approved Protocol Form that you may have on file with Inform Diagnostics.

By signing below, I am aware of the test components, the CPT codes for the components, and the reimbursement rates for the tests ordered. I am also aware that the use of a protocol order may result in the ordering of tests that are not covered. I understand the potential implications of signing a protocol order. I also understand that I have the ability to "Opt Out" of the protocol order for each patient by writing "Opt Out" on the individual test requisition, or for all my patients by contacting Inform Diagnostics' Client Services at 866.588.3280.

I confirm that informed consent will be obtained, if required by state law. I certify that I will discuss with each patient their results and how their results inform treatment recommendations. I attest that the dermatopathologist/dermatologist/pathologist name listed below is authorized by law in the relevant jurisdiction to order the test(s) requested herein. I confirm that I maintain on file each patient's assignment of benefits authorizing insurance benefits to be paid to ancillary healthcare services providers.

Dermatopathologist/Dermatologist/Pathologist _____

Signature _____ *Date* _____ /_____ /_____

Please provide the list of sites you want

1111 S. Freeport Pkwy., Coppell, TX 75019 / 866-588-3280 / Fax: 866-688-3280 / CLIA 45D0975010
4207 E. Cotton Center Blvd., Phoenix, AZ 85040 / 800-768-0958 / Fax: 866-688-3280 / CLIA 03D1064744
15 Crawford St., Suite 100, Needham, MA 02494 / 857-229-1506 / Fax: 617-969-3393 / CLIA 22D0957540

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Dermatopathologists/Dermatologists/Pathologists

Dermatopathologists/Dermatologists/Pathologists _____

Signature _____ *Date* _____ /_____ /_____

Dermatopathologists/Dermatologists/Pathologists _____

Signature _____ *Date* _____ /_____ /_____

Dermatopathologists/Dermatologists/Pathologists _____

Signature _____ *Date* _____ /_____ /_____

This protocol will be effective on the date that the Medical Director at Inform Diagnostics reviews and approves.

Please return the signed form to Inform Diagnostics.

Coppell, Texas
Fax 866-688-3280
E-Mail tcpcproduct@informdx.com

Boston
Fax 617-969-3393
E-Mail tcpcproduct@informdx.com

This protocol form has been reviewed and approved by the Medical Director of Inform Diagnostics.

Signature _____ *Date* _____ /_____ /_____

MEDICAL NECESSITY

*The Centers for Medicare and Medicaid Services (CMS) is responsible for administering Medicare and other federally mandated healthcare programs throughout the United States. Medicare laws prohibit payment for services and items deemed by local Medicare Carriers as not medically reasonable and necessary for the diagnosis or treatment of an illness or injury. In such cases, documentation of "medical necessity" is required before a claim may be paid. Medicare, with a few exceptions, will not pay for routine checkups or screening tests, defined as "diagnostic procedures performed in the absence of signs or symptoms."